NACDS NATIONAL ASSOCIATION OF CHAIN DRUG STORES

NCPA NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

Constructing a Seamless and Effective Health Care Provider Emergency Disaster Response Mechanism

1. **Permanent Agency Responsibilities Should be Established and Communicated**
   Federal response agency responsibilities and protocols should be – to the extent possible – laid out in a permanent structure. These permanent responsibilities and protocols should be clearly communicated to providers when created and again at the time that emergency provider response is requested and, barring unforeseen complications created by the circumstances of the disaster, should remain unchanged throughout the duration of the emergency response and recovery period.

2. **Identification of Agency Liaisons**
   Federal response agencies should, on a permanent basis, publicly designate those individuals with provider liaison responsibilities, nationally and in regional offices, and should communicate these appointments at the time of designation and again when emergency provider response is requested.

3. **Inter-Agency Working Groups with Industry Representation**
   Federal response agencies should create permanent inter-agency working groups that include industry representatives – in the case of pharmacy providers, NACDS and NCPA representatives – with responsibilities for communicating and working with each other and with state, local, and regional agencies. These working groups should put into place, as soon as possible, permanent processes for assigning responsibilities for directing private sector response, and for accepting claims for reimbursement. These permanent processes should be communicated to providers at the time they are formalized and again at the time that emergency provider response is requested.

4. **Contracting for Emergency Services**
   Federal agencies should contract in advance with corporate providers that agree to provide emergency response services and treatment when a federal disaster declaration is issued, registering those providers by chain code or store code for independents – or by NPI number on and after May 23, 2007 – once the contract is signed. Those corporate provider registration numbers should be transmitted to the Medicaid agencies in the impacted states when a declaration is issued, for use in the emergency response.

5. **Uniform Provider Reimbursement Rates for Uncompensated Care**
   Corporate provider emergency service contracts should include a uniform provider reimbursement rate that applies when the patient has no Medicaid, Medicare, or third-party coverage, or when coverage information is unavailable by on-line adjudication at the time the prescription is dispensed. This rate should apply no matter where services or treatment are rendered or where the treated patient/evacuee originated, as long as the patient originated from a county, parish, or zip code specified in a Presidential or federal Department of Health and Human Services emergency declaration.

6. **Uniform Simplified Pharmacy Claims Parameters**
   Emergency response provider contracts for pharmacy providers should include the uniform claims parameters that will be imposed for emergency response services or treatment. Those parameters should be simplified, including no more than:

- Patient name;
- Patient home state zip code;
- Provider chain or corporate ID number (NPI number on and after May 23, 2007);
- A standard process for extending existing prior authorizations, and overriding early refill drug claim rejections and rejections of replacement durable medical equipment;
- Co-pays, co-insurance, and deductibles shown as waived for the duration of the emergency response and recovery; and
- Supply dispensed (with replacement refills limited – for example, to two consecutive 14-day supplies – in accordance with provisions of the provider contract with the government).

The contract also should provide that no more than one prior approval number will be required, and that claims will be adjudicated and paid within 30 days of claim submission.

Once these pharmacy claims requirements are agreed to by contract, state and federal agencies should not be allowed to impose new requirements or change the requirements announced for the duration of a contract period, and never during an emergency response and recovery period, without agreement by contracting providers and amendment of the provider contract.

The federal response agencies and the state Medicaid agencies of the impacted states should work to re-communicate these parameters – through any available electronic and non-electronic means available – to pharmacy providers at the time that a disaster declaration is issued and emergency response is requested.

7. Emergency Response Provider Reimbursement Trust Fund

Federal agencies should seek statutory authorization from Congress for the creation of a continuing trust fund from which at least the initial three months' of provider reimbursement is to be paid in any emergency response and recovery operation. The federal statute should require Congressional funding of an additional three months' of reimbursement prior to the exhaustion of monies maintained within the fund.

8. Backup Point of Sale Adjudication Systems

All state Medicaid agencies should be required by the federal government to have in place, by June 1, 2007, an emergency backup point-of-sale adjudication system with a central hub located outside the state. CMS should provide each state with enhanced Medicaid matching administrative funding to establish the backup system.

When electronic point of sale adjudication systems are disabled during and following a disaster, and backup systems fail to engage, if reasonable provider error leads to the dispensing of a non-covered medication, pharmacy reimbursement should be provided at the provider contract rate. Further, where electronic point-of-sale adjudication systems are completely disabled following a disaster and providers must use paper claims forms to collect claims information for subsequent submission, state and federal response agencies must agree to accept those forms so that emergency providers are not subsequently required to re-collect and re-enter data information for thousands of claims electronically.

9. Uniform Simplified Emergency Registration and Enrollment Procedures

Individual providers employed by contracted corporate emergency response entities should be excused from existing state enrollment requirements and state pharmacy board and other state health department licensing and registration requirements for the duration of the response and recovery period. Facilities utilized by those corporate entities, such as mobile pharmacies, should also be excused from state licensing and registration requirements for the duration of the response and recovery period.

State agencies should utilize a simplified, uniform procedure for temporary state registration of out-of-state healthcare providers and mobile facilities and for temporary enrollment of out-of-state providers and facilities as participating providers in state public health programs such as Medicaid and senior drug programs. The federal response agencies should encourage state agencies to address this issue by some uniform method for facilitating provider practice and mobile facility authorization, such as by enactment of the National Conference of Commissioners on Uniform State Laws' *Uniform Interstate Emergency Healthcare Services Act*. Any such uniform adoption should also include coverage under the impacted state's workers' compensation laws and an exemption from tort liability for services performed and treatment provided during an emergency response and recovery operation.

10. National Patient Database

Federal response agency officials should begin working now with the parties who created the *Katrinahealth.org* information clearinghouse to assemble a similar HIPAA-compliant national clearinghouse of patient information that can be used in future disaster response efforts anywhere in the country. The permanent data clearinghouse should include the claims data elements outlined above, plus the last three months of medication history, as was included in *Katrinahealth.org*, but also should include information about each patient's private insurance, Medicaid, or Medicare, or other public health plan coverage. Where data for a particular patient is unavailable in the clearinghouse database, the clearinghouse should be able to automatically search appropriate national patient databases for third-party coverage and to electronically document such a search.

The National Council for Prescription Drug Programs (NCPDP) also should be encouraged to continue its development of a uniform emergency response claims template that can be integrated with the third-party payor data maintained within the clearinghouse to facilitate the billing and payment of claims. NCPDP is currently working on an approach that would utilize an emergency plan BIN number -- similar to that used by CMS to facilitate billing in the transition to Medicare Part D -- for the billing and editing of claims for displaced patients for whom third-party coverage is not found in a national database and who cannot produce insurance or pay cash. NACDS and NCPA recommend that this BIN number approach be utilized to bill for services and treatment reimbursed at the provider contract rate for uncompensated care.